Statement By James E. Woys
President and Chief Operating Officer
Foundation Health Federal Services, Inc.

Removing the Barriers to TRICARE

Introduction

In a recent report to TRICARE stakeholders, Drs. Bailey and Sears described their vision for the TRICARE Program in three words: Teamwork, Commitment, and Innovation. Their focus for TRICARE in the year 2000 is to make "TRICARE work better for everyone." Foundation Health Federal Services, Inc. (FHFS) shares this goal for the entire system. We understand the importance of recognizing the successes of the current TRICARE program and of strengthening the system with new, innovative solutions.

Ultimately, the government and the managed care support contractors must function as a team to deliver one of the largest and highest quality health care systems in the world. This partnership has been critical to the successes enjoyed by the program thus far and will serve as the basis for advancing the system. In the spirit of teamwork, commitment, and innovation, I present this testimony.

My objective today is to quickly reacquaint this committee with the size, scope, and breadth of Foundation Health Federal Services' commitment to, and participation in TRICARE and briefly comment on the progress we have made in the last few years to improve the program. I will then discuss the barriers that remain to the optimization of the program and whether or not

TRICARE 3.0 addresses these barriers. Finally, I plan to suggest methods for resolving these important issues and demonstrate how these solutions would benefit all TRICARE stakeholders.

Before I begin, I would like to thank Chairman Buyer and the distinguished members of the Committee for your efforts to resolve key issues surrounding the TRICARE Program and for fighting to "Keep the Promise" for all TRICARE beneficiaries. Your actions have greatly contributed to the well-being of the TRICARE Program, and I look forward to working together to continue to improve the program in the future.

Background

FHFS has been with the DoD since the beginning of what is now called TRICARE. We were awarded the first CHAMPUS Reform Initiative (CRI) contract in California and Hawaii in 1988. Since then, FHFS has become the largest TRICARE contractor.

FHFS is the current Managed Care Support Contractor for five TRICARE regions and the State of Alaska covering over 1.6 million TRICARE eligible beneficiaries. FHFS contracts cover the following geographical areas:

Region 6	Texas (excluding El Paso) Oklahoma Arkansas Louisiana (excluding New Orleans)
Region 9	Southern California and Yuma, Arizona
Region 10	Northern California
Region 11	Washington

	Oregon Northern Idaho
Region 12	Hawaii and Alaska

FHFS' parent company, Foundation Health Systems, Inc. (FHS), is the nation's fourth-largest publicly traded managed health care company. Its mission is to enhance the quality of life for its customers by offering products distinguished by their quality, service, and affordability.

FHFS and its subcontractors have over 3,000 employees across the country serving our three managed care support contracts in 11 states. With this level of involvement, I submit that FHFS and its subcontractors are committed members of the TRICARE team. We have the experience in our regions and have successfully mitigated many of the barriers that are perceived to plague the TRICARE program. We have found that the regions with the longest TRICARE history and with contractor continuity are the most successful in meeting the requirements of the program and producing the highest satisfaction levels among all stakeholders. Evidence of this can be found in the ratio of inquiries made by members of congress on behalf of TRICARE eligible beneficiaries, which has steadily declined over the last three years.

Additionally, we have made significant strides in improving the program in areas that have received the most public attention:

- Prime Enrollment
- Claims Processing
- Military Treatment Facility (MTF) Appointments
- TRICARE Service Center Workloads
- Authorizations and Referrals
- Readiness, Resource Sharing, and MTF Optimization

The following information highlights our activities in each of these areas of focus.

Prime Enrollment (HMO)

TRICARE Prime (HMO) enrollment is clearly a success story across all of our regions. In the three contracts that FHFS administers, there are nearly 900,000 enrolled Prime beneficiaries or 176 percent of the original projection. This number swells to over 1.2 million Prime beneficiaries when you include active duty service members. That is nearly three-quarters of the eligible population enrolled in the TRICARE HMO-like option, an exceptional accomplishment in any employer-sponsored health care plan.

FHFS has teamed with MTF commanders and the Lead Agents to successfully enroll the maximum number of active duty and retiree beneficiaries, thereby encouraging the most efficient use of the military health system and strongly supporting DoD's MTF optimization mission. Along with these impressive figures comes the challenge of managing timely and accurate processing of millions of transactions annually. Enrollment and eligibility are processed using three government legacy systems plus the contractor's system. Today, government systems cannot communicate with contractor systems, causing manual processing, duplicate data entry, and impaired productivity and service levels. However, FHFS and Lead Agent staff continuously work to improve processes and have achieved significant improvements in overall service levels since the early years of operation.

Beneficiary satisfaction is at an all-time high as evidenced by a less than 8 percent Prime annual disenrollment rate. Our surveys show that 97 percent of those who disenroll are satisfied with TRICARE and the service they received. This means that less than one-third of one percent disenroll due to dissatisfaction with the program. Principle reasons beneficiaries disenroll other than dissatisfaction include loss of eligibility, transfers, and discharges from active duty.

FHFS, the Lead Agents, and MTF commanders cooperate every day to educate TRICARE beneficiaries, enroll them in Prime, and ensure they receive the best possible service experience with TRICARE.

Claims Processing

Since September 1996, FHFS has routinely met or exceeded claims processing contract standards for timeliness and aging. One measure of this success is the steady decline in the volume of the over 30-day and over 60-day claims inventories. Processing consistency and continuous process improvements allow us to expedite payment to our providers and beneficiaries. FHFS maintains the lowest levels of aged claim inventories in the TRICARE program by focusing on sources of processing issues that prevent timely adjudication.

FHFS Claims Processing Timeliness (All Contracts)

	1997	1998	1999
Processed within 30 days	94.58%	95.01%	97.46%
Processed 30 - 60 days	3.45%	3.40%	1.92%
Processed over 60 days	1.97%	1.59%	0.62%

We place full-time staff at each of our subcontracted claims processing locations to supply hands-on and liaison support for timely identification and analysis of potential problems. Four years of experience have demonstrated the effectiveness of this approach to claims problem identification and resolution. In addition, our subcontracted claims processing staff at all levels is by far the most experienced in processing CHAMPUS claims.

The following table provides the latest national workload results as reported by TRICARE Management Activity (TMA). In this ranking of all regions and contractors, FHFS consistently rates highest in levels of performance. This can be attributed to the maturity of the program, the experience of beneficiaries, the providers, and the level of coordination with our subcontractors.

Retained Claims Processing Timelines - January 2000

Region	Contractor	% Processed within 30 days	% Processed within 60 days
CA/HI	FHFS	97.54%	99.96%
11	FHFS	97.42%	99.61%
6	FHFS	96.99%	99.53%
A	A	94.39%	98.18%
B	B	94.25%	98.58%
C	C	92.65%	97.04%
D	D	88.28%	97.33%

Collections Hotline

In spite of claims processing quality controls and provider education, beneficiaries occasionally are pursued for collection of unpaid claims. In these cases, FHFS has developed a mechanism to intervene on the beneficiary's behalf. Beneficiaries can call to inquire about collection notices utilizing a dedicated toll-free service. Our trained service representatives promptly obtain and analyze information from the beneficiary and initiate action to resolve the situation. We place ourselves directly between the collection agent and the beneficiary. We often contact the provider directly or work with the collection agency to handle inappropriate collection actions. In instances when beneficiaries have failed to pay their cost share, we encourage them to promptly fulfill their obligation. Our objective is to quickly resolve each collection issue. We are typically able to meet this objective within 2 business days.

Toll-Free Telephone Support

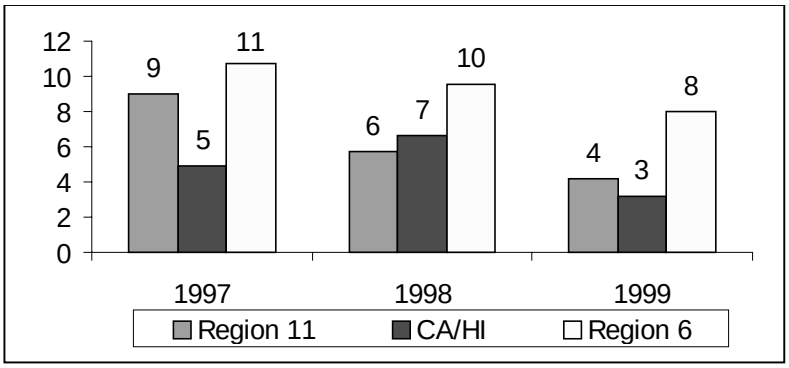
During 1999, we received over 2.2 million calls from providers and beneficiaries in our five regions. Our success in efficiently handling this volume lies in our ability to resolve 98 percent of all inquiries during the initial call. Over 97 percent of remaining inquiries are resolved within 10 calendar days, and all are resolved within 20 calendar days.

Refinements in the claims processing systems, service support processes, customer service training, provider and beneficiary education all contribute to high levels of service and the timely problem resolution.

Congressional Inquiries

Over the last 3 years, the number of congressional inquiries has steadily decreased. We credit this success primarily to our improved performance in claims processing. The bulk of the inquiries we receive involve medical/surgical authorizations, referrals, claims concerns, and program policy issues. In 1999, we responded to approximately 65 inquiries per month from our three contracts. This translates into eight inquiries per 10,000 eligible beneficiaries in Region 6, four inquiries per 10,000 in Region 11, and three inquiries per 10,000 in California/Hawaii. It is important to note that the number of inquiries received and responded to per 10,000 eligible beneficiaries drops consistently as regions mature and stabilize.

Congressional Inquiries Received Per 10,000 TRICARE Eligibles



More than 98 percent of our congressional inquiries were completed within 10 days. Occasionally, an inquiry requires us to rely on external sources for information or involves extensive research, which may extend past a 10-day turnaround. However, we close all of our inquiries within 30 days.

MTF Appointments

As part of our Region 11 contract, FHFS schedules patient appointments for four MTFs with 149 separate clinical services. FHFS is committed to handling appointment requests in a prompt, courteous, and correct manner. We do this by selectively hiring and intensively training our service representatives. We manage this function by monitoring call activity throughout each day and analyzing phone information data. Late last year, our staff worked with GAO representatives in their review of MTF appointment systems. We were pleased to participate in this review and will continue to provide the GAO with information in support of their efforts.

In 1999, we handled 1,058,797 phone calls and 624,512 scheduled appointments. FHFS scheduled 65 percent of all MTF appointments for the four military facilities we service.

Beneficiary dissatisfaction usually surfaces when MTF appointments are unavailable. In these instances, we advise the clinic, in real-time, of the patient's name, phone number, and reason for appointment request. Many clinics use this information to adjust schedules, and in acute cases, actually contact the patient to assist with scheduling needs. FHFS implemented this process in late summer 1998 in partnership with Region 11 and the MTFs. This tool assists the MTF clinics to meet access standards as well as to improve patient satisfaction with the appointment process. Patients do have the opportunity to contact a Health Care Finder for referral to a civilian network provider when MTF services are not available.

The success of our appointment program in Region 11 is due to the strong partnership with the Northwest Lead Agent, MTF commanders and staff. Working with our MTF partners, we have streamlined appointment processes and enhanced customer service. In addition, we applaud TMA's efforts in appointment standardization. From our perspective, appointment standardization will enable the Military Health Service (MHS) to achieve its MTF optimization goals, move towards demand management, and improve patient satisfaction throughout the TRICARE program.

TRICARE Service Center (TSC) Workloads

In 1999, FHFS achieved remarkable customer service levels. The table below shows the volume of calls and walk-ins by region in 1999. Across our regions, FHFS met the service level requirements for over 99 percent of the beneficiary encounters. The total number of walk-ins and phone calls for each of the FHFS-administered regions is shown in the following table.

VOLUME OF WALK-INS AND PHONE CALLS TO TSC'S IN 1999

	Region 6	Region 9, 10, 12 & Alaska	Region 11
Number of Phone Calls	678,200	681,000	1,387,000*
Number of Walk-ins	372,800	238,700	74,530

* Includes phone calls to the Region 11 TRAC.

The reasons for walk-ins to TSCs include:

Enrollment	35%
General Information	26%
Referrals	14%
Other	15%
Claims	9%

FHFS is pleased to report that over 90 percent of TSC walk-ins are for reasons other than claims-related issues. Again, attention to claims processing, as stressed by this committee last year, has proven to reduce concern in this area and has resulted in increased beneficiary and provider satisfaction.

Authorizations and Referrals

I would like to highlight certain aspects of the TRICARE MCS contractors' processes for authorizing services and referrals, and the systems of checks and balances we have to assure that all TRICARE beneficiaries receive necessary and appropriate care within the parameters of the TRICARE benefit.

During the third quarter of 1999, we rendered approximately 8.5 million medical services in the civilian environment for TRICARE beneficiaries. Excluding the one million services related to pharmacy that are not subject to the referral or authorization process, we provided 7.5 million medical services during this 3 month period.

The goal of our DoD-approved utilization management program is to assure that services rendered conform with nationally accepted standards for appropriateness of care. During the third quarter of 1999, FHFS reviewed approximately 148,000 referrals and authorizations. Ninety-five percent were approved at the first level by nurses using DoD-approved guidelines. The remaining five percent of requests (approximately 8,000) were referred to physicians for second-level review. Only physicians may deny requests for services and only physicians of like specialty in active practice may deny services based on a medical necessity determination. Only one in 4,000 services were ultimately denied in the third quarter of 1999 based on these criteria.

Whenever FHFS issues a denial, we notify the beneficiary of his/her appeal rights. Of the 2,000 services denied in the third quarter of 1999, roughly 15 percent were appealed, half of which were upheld. FHFS' process for performing reconsiderations and processing appeals has received significant management attention and the active input of the DoD. All reconsiderations are reviewed by physicians other than those involved in the initial denial determination. Denials based on a limitation of the TRICARE benefit are reviewed by a different FHFS Medical Director than the one who made the initial determination. A medical necessity denial is reviewed by a physician, in active practice in the region, other than the one who made the initial denial determination.

If the reconsideration upholds the initial denial, the beneficiary may appeal that decision in conformance with our appeals program. An appeal of a denied benefit determination is then forwarded to TMA who refers the case

to either policy analysts and/or one of their peer review physicians. A medical necessity determination is appealed to the National Quality Monitoring Contractor (NQMC). The NQMC refers the case to a physician of like specialty to make the appropriate medical necessity determination. FHFS consistently exceeds all TMA timeliness standards by processing 100 percent of non-expedited appeals and reconsiderations within 30 days from receipt. Expedited appeals are handled on a priority basis to ensure timely decisions that support the health care needs of the beneficiary.

FHFS has embarked on a major project to reduce the number of authorization requirements and streamline the process for providers and beneficiaries. This is expected to achieve greater efficiencies in our utilization management program and appeals process as well as provide higher levels of service. We work in collaboration with Lead Agent and TMA staff and are proud of the progress we are making in this area.

Readiness, Resource Sharing and MTF Optimization

One thing FHFS acutely understands is how TRICARE truly supports the readiness mission of DoD. One aspect of the Resource Sharing program is to support readiness through the recapture of health care services into the MTFs and clinics. This program had its challenges in the early years of operation, causing contractors to seek resolution through equitable adjustments or other remedies. However, 1999 proved to be a turnaround year for the program.

In an extraordinary example of teamwork among MTF commanders, Lead Agent staff and FHFS personnel, TRICARE Resource Sharing results have

come close to reaching the expected levels of activity originally set out in our contracts. In 1999, FHFS and the government assembled "Power Teams" that sought out new opportunities to bring beneficiaries' health care back into the base clinic or hospital. We were able to recapture over 800,000 outpatient visits and nearly 13,000 inpatient admissions in 1999. This achievement has enabled military medicine to maintain the proficiency levels necessary for its readiness mission while assuring beneficiary access to quality care. Together, we have achieved the goals set by TMA to support the MTF optimization initiative now underway across the entire TRICARE program.

Major Accomplishments during 1999

TRICARE is meeting or exceeding almost all recognized standards for satisfaction, timeliness, and quality. In fact, the 1999 Congressional TRICARE Evaluation Report, prepared by the Center for Naval Analysis (CNA), showed the program has made tremendous improvements in beneficiary satisfaction. According to the study, in Region 11 alone, there has been a substantial reduction in emergency room visits caused by a significant increase in access to care, in and out of the MTF. Satisfaction with TRICARE is up more than 20 percentage points over a 3 year period. Perceptual measures of quality such as thoroughness of treatment, provider skills, examination completeness and perceived outcomes have all increased dramatically. These critical improvements happened because of a collaborative effort among all TRICARE stakeholders to make things better.

FHFS successfully implemented 35 change orders in each of our three contracts during 1999. TMA-directed improvements implemented during 1999 that had a significant impact to the TRICARE program were:

- Automatic Prime Re-Enrollment
- TRICARE Senior Prime
- Y2K Business Resumption Planning
- Work Simplification, Phase I & II
- TRICARE Prime Remote
- Supplemental Health Care Program

In addition to TMA-directed changes, FHFS undertook major projects to further the goals of the program in its regions. Among these was a new teaming arrangement with Northern California VA Centers for Specialized Treatment Services (STS) services.

Veterans Administration (VA) Cardiac Specialized Treatment Services (STS)

A recent agreement between the DoD and the VA hospitals in Palo Alto and San Francisco allows for these two centers of excellence to be the institutions of choice for TRICARE patients requiring heart surgery. Nationally recognized cardiothoracic physicians and surgeons provide care at both of the medical centers.

The Palo Alto VA is affiliated with the Stanford University School of Medicine and San Francisco VA is affiliated with the University of California, San Francisco School of Medicine. These schools are recognized as world-class health care organizations and all cardiothoracic surgeons practicing at both VA facilities hold faculty appointments. In addition, the

high quality medical and surgical programs at both institutions exceed the clinical and facility criteria for STServices (STS) designation established by the Assistant Secretary of Defense (Health Affairs).

Future System Changes in 2000

Major changes directed by TMA and scheduled for implementation during 2000 include National Enrollment Database (NED) and Primary Care Manager (PCM)-by-Name. FHFS has received an average of one new change order per week for each of the three contracts since the beginning of 2000. In addition, we have received 11 drafts - government requests to evaluate a proposed change - this year. Two of the drafts that may have significant impact during 2000 are Automatic Enrollment of Family Members of E-4 and Below and Corporate Services by Provider.

NED

This new TMA initiative for 2000 is being launched to minimize the enrollment system issues we referenced in earlier remarks regarding computer system incompatibilities. NED is significant because it requires the complete reconciliation of every enrollment record at the MTF level in coordination with the MCS contractor. This effort also supports the PCM-by-Name directive that was announced this year as a part of the MTF Optimization initiative. There are significant resource requirements on the part of the contractors and the government necessary to affect this change by the anticipated deadline of August 7, 2000. The data reconciliation, government-supplied tools, system modifications, and coordination among all participants will be crucial to a successful implementation.

e-Commerce

FHFS and our parent company, Foundation Health Systems, Inc., has made a commitment to developing an e-commerce model that will transform the way we do business. This service will give beneficiaries and providers with the necessary information and linkages to allow them easy access to a number of TRICARE services.

The first phase of our strategy will offer our beneficiaries online enrollment into the TRICARE program. Beneficiaries will also be able to update their personal information online, record changes in dependent eligibility, and reference information on network providers. The subsequent roll-out of this program during 2000 will include a provider-based initiative that gives doctors' offices access to patient eligibility online, easy access to referral and authorization requests, online provider directories, claims inquiry and submission, and pharmacy formulary support. All of this will be accomplished in a secure environment with the patients' privacy receiving the utmost concern and attention.

Quality of Care

The Quality Management (QM) plan implemented by FHFS in its regions has several program components that mirror commercial, Medicare and Medicaid quality management programs, including credentialing**,** quality of care studies, and provider profiling.

Before the TRICARE MCS contract was introduced throughout the country, providers could be reimbursed for rendering services to eligible beneficiaries

if they met the administrative requirements of being a CHAMPUS-authorized provider. This required little more than submitting a copy of a medical license and a signature. By contrast, to become a network provider in TRICARE, providers now must undergo rigorous credentialing, similar to other managed care organizations. Providers included in our network have satisfactorily demonstrated eligibility and the appropriate specialty. A partial list of credentialing requirements include:

- Verification of professional school graduation (i.e. medical school)
- Completion of internship, residency, and fellowship
- Medical specialty board certification status
- Review of malpractice history and current coverage
- Review of a confidential personal questionnaire
- Review of affiliations with accredited and MCS contractor-affiliated hospitals and institutions

The process of scrutinizing our provider network allows us to facilitate the delivery of necessary care. Once a provider has been credentialed, we then include him/her in our provider directories and our Health Care Finders selectively refer beneficiaries to these providers. The referral process into our credentialed network provides the first and best opportunity for our beneficiaries to obtain optimal health care outcomes.

Under TRICARE, we submit an annual QM plan to the Lead Agent that describes our activities for the coming year. Among the activities outlined in the annual QM plan are prospective and retrospective reviews. These typically focus on clinical areas that may be considered high volume,

potential high risk, or problem-prone conditions due to the clinical circumstance of the population. Under our three current TRICARE contracts, we have over forty quality management studies in various stages of completion which are assessing and trying to better understand and manage identified areas of clinical interest. These studies are developed, overseen, and analyzed with the active involvement of our FHFS management, Lead Agent and MTF professionals, and civilian network providers. Some of the clinical areas of study include breast cancer, hysterectomy, cesarean section, acute myocardial infarction, asthma, depression, immunization, depression, and cholesterol screening. These analyses allow us to validate our conformance to national standards and to continually identify opportunities for improvement in the care delivered by our network to our beneficiaries. The introduction of these activities to the TRICARE population is a substantial enhancement to the quality of the health benefit plan these beneficiaries now receive and has no precedent in the scope of the precursor fiscal intermediary administrative services.

Provider profiling is an activity of the managed care process that allows for continuous evaluation of care by the network providers to whom we refer large numbers of beneficiaries. FHFS actively accumulates and integrates various outcome measures to assess the appropriateness of provider network affiliation and uses this information for review during our biannual review of network providers. During this process, we address any quality issues, complaints or grievances, patterns of aberrant utilization practices, or deficiencies in meeting accessibility or other service standards that have arisen with a provider. FHFS also performs provider profiling, aggregating

providers in larger specialty specific or regional groups to identify opportunities for improved care for our beneficiaries.

Barriers to TRICARE

I believe we all understand how important the TRICARE program is to our nation's defense and the well-being of our service members. Since we share many of the same concerns in optimizing the TRICARE program, we must work together to meet our objectives. Unfortunately, there remain hindrances in the system that prevent us from meeting our goals for the program. These can be grouped into six categories:

- Budget and Funding
- Uniformity and Portability of Benefits
- Provider Access Challenges
- Program Education and Complexity
- Data Issues
- The Individual Case Management Program

It is extremely important to note that FHFS does not believe claims processing remains a barrier in our regions. FHFS and its claims processing subcontractors, with the help of TMA, have given considerable effort during the past few years to making TRICARE claims processing superior in timing and accuracy to most commercial or government comparable systems. As discussed above, we have focused our staff on processing consistency, accuracy, and most important, claims aging. As of today, we have less than 1,000 claims in inventory over 60 days old.

Budget and Funding

TRICARE, like many other DoD programs, is faced with financial constraints that adversely impact the program's ability to deliver its mission. The results of these limitations manifest themselves at every level of the program. To highlight the kinds of issues that arise from budgetary and funding shortfalls, I reference some real world examples of problems that occur throughout the TRICARE system.

MTF Optimization

A primary objective of TRICARE is MTF optimization. Policy-makers would like the MTFs to operate more efficiently and to capture perceived cost savings associated with in-house care. This makes perfect sense until the issue of support personnel, physical plant limitations, and ancillary services are brought into the equation. In many cases, staffing, military construction budgets, and support services have been cut and do not support MTF optimization. In addition, MTFs lack the systems and infrastructure to facilitate provider productivity. Manual systems, facility limitations, and a lack of sufficient support services are all barriers to the overall goal of MTF optimization. Although the MTFs face certain operational challenges, we recognize that the DoD is implementing a comprehensive plan to improve MTF performance. FHFS looks forward to assisting TMA in these efforts.

Contractor Payment

The face of health care is rapidly changing, and TRICARE must strive to keep up with basic elements of the industry. Unfortunately, a major barrier to TRICARE's advancement is the contracting process that does not provide for timely cost reconciliation when the government makes changes to the

program or when the current faulty contract mechanisms do not adequately compensate the contractor for work performed.

A critical issue that must be addressed by Congress and the Department of Defense is the growing amount of dollars owed the managed care support contractors. The causes for this growing unbudgeted cost for DOD is due primarily to the following (including appropriate relative percentage of FHFS's accrued receivable):

- Backlog of un-negotiated change orders (9%)
- Shifting of pharmaceutical costs from the direct care system to civilian pharmacies (23%)
- Resource Sharing program (14%)
- Faulty inflation adjustment of the contracts (9%)
- Other faulty contract provisions (20%)
- Bid Price Adjustment data quality issues and unprecise formulas (25%)

During the past several years, funding problems in the Defense Health Program has inadvertently shifted a portion of the cost of providing health care benefits for the TRICARE population to the managed care support contractors. As the direct care budget has been decreased, military facilities have downsized, closed, eliminated, or reduced services. Thus, more and more of the TRICARE health care dollar is spent in the civilian sector. This shifting of care only exacerbates the reasons for these funding shortfalls.

Frequently, if not always, the contractor is required to implement a change and then negotiate the price adjustment after the fact. A substantial number of the changes that have taken place over the last few years have yet to be reconciled. As a result, contractors are carrying substantial receivables that are frequently several years old.

There are numerous examples that highlight this issue. The one that is most familiar to this committee is the shift of pharmaceutical expenditures from the military pharmacy to the civilian pharmacy. This issue was first addressed with DoD in April 1996. After nearly 3 years of discussions with DoD, it was this committee that authored legislation in last years Authorization Act to provide for an adjustment to the contractors contract to fix the glaring inequity of the situation. I am glad to report that substantial progress has been made as of this date. DoD and FHFS are close to an agreement that will finally reconcile this outstanding liability. I am hopeful this issue will be resolved within the next few weeks. Mr. Chairman and members of the committee, thank you for your support on solving this issue for the contractors.

The issue of funding and the realities of mounting receivables weigh heavy on MCS contractors and will adversely effect this program if not handled expeditiously.

Uniformity and Portability of Benefits

The DoD has a stated objective of creating a uniform TRICARE benefit across the entire country. This objective resonates with most beneficiaries and, though desirable, is virtually impossible to realize in practice. When

coupled with subjective and highly variable ideals such as commercial best practices, MTF optimization, and cost controls - the result is a set of competing objectives.

Uniform benefit administration is relatively simple under a fee-for-service health care delivery model; however, Mr. Chairman, you and every member of this committee have unique health care markets and delivery models in your home districts. California, my home state, is recognized as a mature market, yet Sacramento is substantially different from San Diego in terms of health care delivery and cost structure. The differences grow exponentially when you compare this to the market in Abilene, Texas where we support 17,000 lives around Dyess AFB in Region 6 and in Los Angeles where we support approximately the same number of lives in a mature managed care environment. The contrasts are significant, and I'd like to take a minute to explain how and why.

In rural areas where physicians and hospitals have not been exposed to managed care and where there are relatively few medical professionals and facilities, the TRICARE contractor has less ability to negotiate provider discounts and to implement patient management mechanisms. As a result, the beneficiary in this market will have a different experience than he/she would have in an urban setting.

In more mature managed care markets, physicians and hospitals are accustomed to providing discounts and complying with the requirements of managed care. The difference in these markets is the penetration of managed care as well as greater competition among providers and hospitals.

The result is a significant difference in the delivery and administration of the TRICARE benefit in the various regional markets.

In addition to the varying health care markets, each contractor's definition of *commercial best practices,* derived from unique business experiences, contributes to the variation in benefit administration and delivery. With these two competing objectives as part of the TRICARE program's goals for 2000, the best we can achieve is a uniform understanding of the TRICARE principles and a flexible application on a regional basis.

Access to Care

Provider access, though greatly improved in the last few years, continues to be a barrier to the TRICARE program. The two substantial problems that affect access to care are reimbursement levels to civilian providers and over-enrollment into the Direct Care System.

Reimbursement rates for TRICARE or CMAC continue to disappoint the medical community. TMA has established a policy of adjusting CMAC rates to equate rates paid by fee-for-service Medicare. Unfortunately, the TRICARE program is not a fee-for-service non-managed care program. TRICARE may use the rate schedules equating to Medicare, but this program is a triple-option full-managed care program. TRICARE contractors not only require discounts from these fee schedules, we also require our network providers to be subject to all the managed care rules: referrals and authorization procedures, office wait times, credentialing requirements, and complex claims filing requirements. Consequently, TRICARE must be willing to either substantially reduce the administrative

load associated with the program, raise reimbursement to support the additional requirements, or suffer provider attrition on a national basis. As providers become more sophisticated in their managed care business practices, they are beginning to withdraw from unprofitable payer contracts.

MTF access is an even greater barrier to health care access for our beneficiaries. Under alternative financing, MTF commanders have an incentive to enroll as many beneficiaries as possible into their systems. The goal of TMA is to optimize the MTF and increase the productivity of the MTF provider. The current challenge of DoD is recognizing that the MTFs are not equipped to manage large numbers of primary care visits. Physicians in the MTFs rotate regularly and have other duties that do not involve patient care. Applying commercial physician-to-patient ratios for primary care, as is being done today in the Direct Care System, might actually conflict with the readiness mission and the realities of military medicine.

Program Education and Complexity

Health benefit plans, public or private, are highly regulated, complex, and difficult to communicate. TRICARE is no exception to this problem. The challenges with communicating and marketing such programs to beneficiaries who are often uninitiated to the complex world of managed care are daunting. The hurdle grows even higher when faced with the highly mobile TRICARE beneficiary population.

This barrier to TRICARE presents an excellent opportunity for improvement to better communicate a consistent message to our beneficiaries. The program is administered by a tremendous bureaucracy including: OSD

(HA), TMA, the DMOC, 12 Lead Agents, three Surgeons General, approximately 480 MTF Commanders, five MCS Contractors, two fiscal intermediaries and countless health benefit advisors and customer service representatives. This coupled with benefit variances by region, public opinion, and the informal network of advisors in the beneficiary community, makes the program difficult to administer for all involved.

One solution to this problem might be to create a national training program for all government and contractor personnel to gain common, comprehensive training on TRICARE benefits and policy. The agency or contractor responsible for this program could also be the source for consistent marketing materials and a forum for discussing important issues facing the program.

Data Issues

Managed care is, in effect, managed information. Through TRICARE, the Military Health System and the MCS contractors are inextricably linked by data. When critical program data is compartmentalized and unreliable, systems breakdown and costs escalate. TRICARE is faced with these problems due to multiple and unique data systems that are often incompatible and obsolete. One major example of TRICARE's system problems is claims processing. TRICARE has one of the highest per claim transaction costs and lowest electronic media claim submission ratios in the heath care industry. While every payer is working to upgrade claims processing systems and reduce administrative costs, TRICARE is struggling to maintain an antiquated system.

TRICARE has both a tremendous challenge and an opportunity going forward. When the program began as the CHAMPUS Reform Initiative in 1988, it was based on a modified fee-for-service model administered by three regional fiscal intermediaries. The opportunity exists for TRICARE to migrate to relational data base technologies and the World Wide Web. This change would greatly relieve many of the barriers that prevent the program from advancing.

Individual Case Management Program

An additional concern with TRICARE today is the Individual Case Management Program (ICMP).

FHFS has been actively involved in the ICMP since early last year. FHFS has 12 cases actively participating in the program, four that have been denied and five pending authorization to participate, waiting for TMA approval as early as December 12, 1999.

FHFS currently administers the ICMP as per the interim instructions provided by the DoD in January 1999. Included in the interim instructions is a requirement for a Beneficiary Acknowledgement form that requires the beneficiary's signature prior to consideration of participation. This form has become a contentious issue for beneficiaries. Primary concerns are (1) the beneficiaries will lose their standing with Medicaid if the ICMP is terminated, which could impose a serious health risk and (2) how and by whom cost effective and clinically appropriate care will be defined. These concerns are further intensified by the fact that DoD has not yet published

the new ICMP regulation in its semi-annual Regulatory Agenda, and the contents of that regulation are unknown. Also, new cases pending authorization to participate are being held awaiting a Policy Memorandum clarification from TMA, which also has unknown content.

FHFS also has concerns with the program. Beneficiaries that are being considered for participation in the program are on a clinical timetable that does not match TMA's timetable for approval. Pending these cases for a prolonged period of time could put the beneficiary's health at risk and FHFS in an extremely awkward situation of upholding current policy and withholding care due to current program exclusions.

The revised definition of Custodial Care under the Department of Defense Appropriations Act for FY 2000 appears to eliminate the need for an exception to benefits offered under the CHAMPUS program. This in itself offers the question of the need and longevity of the Individual Case Management Program. Add to this the language in S.2087, Military Health Care Improvements Act of 2000 under Section 302 titled, "Provision of Domiciliary and Custodial Care for CHAMPUS Beneficiaries," and it becomes unclear how this legislation will impact TRICARE beneficiaries and who these beneficiaries really are.

Clarification of the future of the Individual Case Management Program and the impact the revised definition of Custodial Care will have on current policy would be greatly appreciated.

TRICARE 3.0

Earlier this year, DoD presented their "Joint Overview Statement" to the Senate Armed Services Committee. On page seven of the published version of this testimony, the following statement is made:

> "Optimization of the Military Health System will be more successful with the implementation of TRICARE 3.0, the new generation of the TRICARE managed care support contract. TRICARE 3.0 moves away from highly prescriptive, government-developed requirements and processes; identifies government-required outcomes and invites bidders to propose their best commercial practices to meet or achieve government required outcomes; reduces cost for separately designed contractor systems and practices to meet requirements unique to the government and gives government more effective, more immediate authority to enforce performance of the MCS contractors in such areas as claims processing, appointments, and access standards."

Although the intent of this statement is sound, I believe its application has significant limitations.

In discussing the TRICARE 3.0 initiative, I would like to reinforce that FHFS, as a company, is fully committed to the goals of the TRICARE program. Conversely, if TRICARE 3.0 proceeds as written, my company will regretfully consider withdrawing from the TRICARE market. This, Mr. Chairman and members of the committee, is not a threat, but a possible business decision by FHFS and the management of our parent corporation. Of major concern is the implementation of these substantial changes to the health care delivery system without fully understanding their impact on the beneficiaries, providers, and the overall TRICARE program. Now is not the

time to place the TRICARE program at unnecessary risk by implementing unproven concepts that have the potential to undermine desired stabilization.

In my opinion, TRICARE 3.0 represents a tremendous liability for MCS contractors. In this round of MCS contract procurements, the government is asking contractors to go into business with the Military Health System. In the RFP, we are told that the MTFs will function as network providers and will submit a report of MTF care no later than the 20th day of each month. The provider is then required to deduct its monthly at risk invoice (DD 250) in accordance with the invoice submittal. The contractor is only allowed to dispute items in excess of $10,000 dollars, well above the average single health care claim. The government will audit its own disputes and all claim amounts will be based on a discount off of CMAC.

This sounds reasonable when considering the MTF as a network provider; however, it is not reasonable considering the financial ramifications of this approach. The MTFs are not structured or staffed to handle complex business office functions. Coding, claims processing, and reconciliation all appear to be major obstacles to this approach. In addition, the contractor is placed in the position as the government's bank as it pays for claims of MTF beneficiaries seeking services outside the MTF until the contractor can be reimbursed by the government.

Other potential problems include adverse selection. MTFs are not, on an individual basis, equipped to take risk for high-cost patients. The risk pool is far to small to allow acceptable distribution of risk, therefore MTFs will be forced to recommend that patients with complex medical problems be re-

enrolled with the civilian contractor. It is also possible that the MTF and contractor will compete for healthy beneficiaries - cherry-picking - while trying to move the high users of care to each other's risk pool.

Another major issue is the adversarial relationship that is likely to develop when MTFs and contractors attempt to collect money from each other for services. The RFP gives the MTF access to complete billing documentation without giving the contractor any right to audit this information. This goes against health care industry practices and would not be acceptable for a public company, like Foundation. Further, the potential for an adversarial relationship that could negatively affect the beneficiary is extremely high.

Most importantly, the heightened standards for MTF enrollment leaves the MCS contractors with the mostly non-enrolled population (Standard and Extra) which leaves little opportunity for cost savings beyond network discounts. The MCS contractor is left with the responsibility and risk of managing a non-enrolled, virtually unmanageable, population.

The next stated objective of TRICARE 3.0 is its departure from "prescriptive, government-developed requirements and processes." This concept purports to give contractors an opportunity to "propose their own best practices to meet or achieve government outcomes." This is clearly an important component of acquisition reform, however, it is not the unifying principle of this procurement. The RFP remains highly prescriptive as it continually refers to the TRICARE Manuals, which prescriptively define almost every possible aspect of the program. These manuals outline onerous

guidelines that require contractors to interact with technology and regulations that have no commercial application.

In the current 3.0 RFP, there are over 100 prescriptive performance requirements, most of which are absolute standards. Any deviation from these standards imposes immediate penalty on the contractors. I am not opposed to holding contractors accountable for their performance, but standards and penalties as these, not common in industry, will only bring further adversity between contractors and DoD, on the heels of establishing outstanding partnering relationships.

Rather than have failed attempts to apply commercial best practices, the government should work to move the system forward in partnership with contractors. The procurement process is not the appropriate vehicle for this type of system advancement.

There are many examples of contradiction in this RFP. Claims processing is one major example. The RFP replaces Health Care Service Records (HCSRs) with TRICARE Encounter Data (TED). These somewhat streamlined data requirements continue to be driven by the TRICARE Systems Manual, not by commercial best practices or industry standard formats and data sets.

I firmly believe we should be striving to deliver to our population a consistent, portable, uniform benefit. The untested practice of allowing contractors to propose “best practices” could have a substantial impairment on this concept.

A health care example that illuminates the issue of standardization and portability involves utilization management and review standards. Take mental health, for example: TRICARE has historically mandated that contractors apply a single set of utilization management criteria. Consequently, with minor exceptions, the mental health benefit has been uniformly administered across the country, mitigating disruption in continuity of care and beneficiary dissatisfaction when transferring from region to region. In TRICARE 3.0, there are no determined standards, therefore beneficiaries may be subject to vastly different treatment standards on a regional basis, causing disruption and dissatisfaction.

Expanding the application of multiple best practices throughout the administration of all benefits and operational processes will potentially destroy program portability and the uniformity of benefits. Therefore, program-wide benefit uniformity can only be sustained when best business practices are standardized and not left to multi-contractor interpretation. Commercial best practices have a tremendous upside for TRICARE contractors and for all of us as taxpayers. The issue is where and when to apply these concepts and what impact they will have on the program.

Finally, TRICARE 3.0 gives the government immediate authority to enforce performance standards by penalizing MCS contractors for non-compliance. This translates into an incentive program that rewards the contractor based upon subjective criteria and penalties based on absolute standards. The flaw exists in the subjective criteria such as beneficiary satisfaction surveys and MTF commander satisfaction. The GAO has reported that beneficiary

satisfaction surveys are unreliable measurements of performance. In addition, many of the other elements of TRICARE 3.0, including monthly reconciliation with the MTFs, will inevitably cause friction between the contractor and the MTF commanders.

These are important concerns my company has with TRICARE 3.0 that make us take pause and reconsider our interest in pursuing a contract under this model. Without certain important modifications, this procurement may mark the end of a long and mutually beneficial relationship between the DoD and FHFS.

Conclusion

As stated in my introduction, I see my company as partner in the TRICARE program. My purpose is to help TRICARE survive and improve. I am often asked why there is not more interest shown in TRICARE by other major players in the managed care industry. My answer is simple - most who have entered this market and won, tend to continue. Most who have entered and lost, tend not to return, and those that look for the first time see the complexity associated with the program and tend to walk away. Step back and take a good look at TRICARE 3.0. I suggest that even the incumbent players will have a hard time justifying continued participation to their shareholders and directors.

So what can we do? Well, may I suggest teamwork, commitment, and innovation. Let us work as a team to develop TRICARE 3.0 correctly. We should first stabilize the program and resolve the open procurement in Regions 2&5. Then, as a team, take a mature market such as Region 11 and

test the concepts put forth in the current 3.0 RFP. Perhaps we can move away from the old concept of a demonstration project and cooperatively work on the program in the form of a development project. I suggest we create a project team that includes stakeholders from all constituencies. As with the original CRI program we should first test the program, then move forward with the procurement schedule.

Should the concept of testing TRICARE 3.0 meet with substantial resistance, then I suggest we take TRICARE to the next level and modify the risk model. In effect, take the program full circle and return to a progressive, Administrative Services Only (ASO) model. This approach would be more consistent with commercial best practices for large, self-insured employers. The ASO option would require a major paradigm shift in the program, but is a more feasible solution when you consider the unacceptable amount of contractor risk inherent in the current 3.0 model. My company is heavily invested in this program and we are committed to its success. We have made significant strides since our beginnings in 1988 and we have accomplished many great things. My testimony today may be seen as a cry for the status quo. I assure you it is not. It is simply a call for reason in an effort to preserve the ideals of a program we have all worked so hard to create.